

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05937 | | | | | | | | | | 05984 | |
|--|--|--|--|--|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield, Maryland d. STREET ADDRESS Traylor 10, Landon Point e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Infant Middle Female Last Brock | | 4. DATE OF DEATH Month Apr Day 17 Year 19 66 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 16, 1966 | |
| 9. AGE (In years last birthday) No yrs. | | 10. IF UNDER 1 YEAR Months No Days 1 | | 11. IF UNDER 24 HRS. Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Robert E. Brock | | 14. MOTHER'S MAIDEN NAME Martha Baine | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Robert E. Brock, Same as 2. abcd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal - 7620 DUE TO (b) Caesarean Section, mother became Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) severe vag. and infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 4/17/66 19 , and that death occurred at 5:20 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE S. M. Peyton | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) S. M. Peyton, M.D. | | 22d. ADDRESS Crisfield, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April 18, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery | | 23d. LOCATION (City, town or county) (State) Crisfield, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland | | 25a. REC'D BY REGISTRAR APR 20 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

| <div>1</div> <div>M</div> <div>05938</div> <div>05935</div> | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--------------------------------------|--|---|---|--|
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| <div>1</div> <div>M</div> <div>05938</div> <div>05935</div> | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Somerset MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Marion Station | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital | | | | | | d. STREET ADDRESS R. F. D. | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Lake Middle Conner Last Conner | | | 4. DATE OF DEATH Month Apr. Day 30 Year 1966 | | | 5. SEX Male | | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH Nov. 1, 1896 | | | 9. AGE (In years last birthday) 69 yrs. | | | IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. | | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | | | 10b. KIND OF BUSINESS OR INDUSTRY County Roads Comm. | | 11. BIRTHPLACE (County & State, or foreign country) Marion Station, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Joseph W. Conner | | | | | | 14. MOTHER'S MAIDEN NAME Drucilla Corbin | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 220-32-1598 | | 17. INFORMANT Mrs. Lucille Conner, same as 2, a.b.c.d. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease, Coronary Artery Disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) General Arterio Sclerotic & Chronic Hypertension DUE TO (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arterio Sclerotic INTERVAL BETWEEN ONSET AND DEATH 4-30 | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) — | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-20 , 19 66 to 4-30 , 19 66 , that (I) (we) last saw the deceased alive on 4/30/66 19 66 , and that death occurred at 9:20 M, from the causes and on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE G. C. Coulbourn | | | | | | 22b. DATE SIGNED MAY 5 1966 | | | 22c. PHYSICIAN'S NAME (Type) G. C. Coulbourn, M.D. | | | |
| 22d. ADDRESS Crisfield, Maryland | | | | 22e. ADDRESS Crisfield, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF May 3, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | | 23d. LOCATION (City, town or county) (State) Marion Station, Md. | | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md. | | | | | | 25a. REC'D BY REGISTRAR MAY 5 1966 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR #15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | |
|---|--|---|--|---|--|
| 059339 CERTIFICATE OF DEATH 059336 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b 25 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Hill d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Blanche Middle Handy Last Handy | | | 4. DATE OF DEATH Month Apr. Day 4 Year 1966 | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 6/6/1898 | | 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD | | 11. BIRTHPLACE (County & State, or foreign country) Kingston Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Med Selby | | 14. MOTHER'S MAIDEN NAME Ellen Coston | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 218-33-9117 | | 17. INFORMANT Helen Johnson Address Upper Hill Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Apr. 4 19 66 , and that death occurred at 7:15 from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE R. E. Roberts | | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D. | | | | 22d. ADDRESS Crisfield, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 4/9/66 | | 23c. NAME OF CEMETERY OR CREMATORY ST. ANDREWS | |
| 23d. LOCATION (City, town or county) (State) Fairmount Md. | | | | | |
| 24. FUNERAL DIRECTOR Anthony C. Ward | | 25a. REC'D BY REGISTRAR APR 11 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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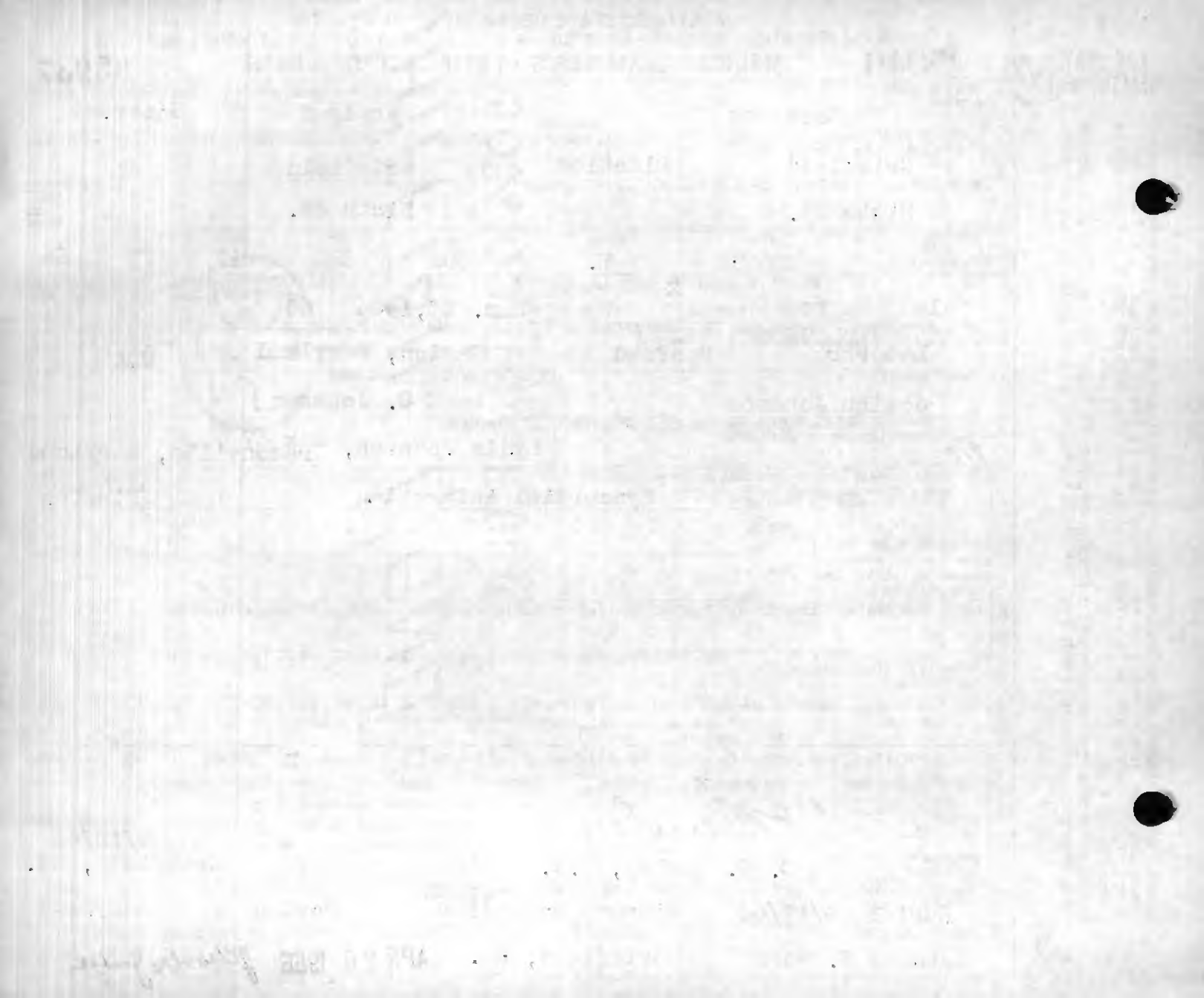
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FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|---------------------------|---|-----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Somerset MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield | | c. LENGTH OF STAY IN 1b Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 19-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ninth St. | | | | d. STREET ADDRESS Ninth St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WEBSTER | | First T. Middle | | Last JOHNSON | | 4. DATE OF DEATH Month April Day 13 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 15, 1906 | | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | | 11. BIRTHPLACE (State or foreign country) Marion, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Josiah Johnson | | | | 14. MOTHER'S MAIDEN NAME Anna B. Johnson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lydia Johnson, Box 67, Grasonville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE C. G. Rawley | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 4/18/66 | |
| EXAMINER'S NAME (Type) C. G. Rawley, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) Crisfield, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/17/66 | | 23c. NAME OF CEMETERY OR CREMATORIUM Library Methodist | | 23d. LOCATION (City, town or county) (State) Marion Maryland | |
| 24. FUNERAL DIRECTOR Anthony E. Ward | | | | ADDRESS Crisfield, Md. | | 25a. REC'D BY REGISTRAR APR 20 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



FOR STATE
HEALTH DEPT.

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VR A15ME
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05941

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05938

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| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westover | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westover | |
| c. LENGTH OF STAY in 1b 17 years | | d. STREET ADDRESS --- | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --- | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last OLIVER HERMAN KING | | 4. DATE OF DEATH Month Day Year April 8 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 2, 1902 |
| 9. AGE (In years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Elmer King | | 14. MOTHER'S MAIDEN NAME Sarah Elizabeth Blank | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -- | | 16. SOCIAL SECURITY NO. 279-22-6181 | |
| 17. INFORMANT Mrs Genevieve King, Westover, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Everett Sutter</i> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Everett Sutter MD | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED 4-9-66 | | Address (Street, city, town, or county) Somerset | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-10-1966 | |
| 23c. NAME OF CEMETERY OR CREMATOR Holly Grove Mennonite | | 23d. LOCATION (City, town or county) (State) Somerset County, Md. | |
| 24. FUNERAL DIRECTOR <i>Robert H. Watson</i> | | 25a. REC'D BY REGISTRAR APR 11 1966 | |
| ADDRESS Pocomoke City, Md. | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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CERTIFICATE OF DEATH

Reg. Dist. No. 05930

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sennetta</u> First <u>G.</u> Middle <u>Logan</u> Last | | | | 4. DATE OF DEATH <u>April</u> Month <u>11</u> Day <u>1966</u> Year | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 14, 1876</u> | |
| 9. AGE (In years last birthday) <u>89</u> yrs. | | IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u> | | IF UNDER 24 HRS Hours <u></u> Min <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Hopewell</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Alfred Miles</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sabre Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>213-14-7302</u> | | 17. INFORMANT <u>Mrs. Hazel Goswell</u> Address <u>Marion</u> <u>Fl. 1 Box 361 Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute dilatation heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocarditis chronic</u> DUE TO (c) <u>Gen'l arteriosclerosis - Senility</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>11/7/46</u> 19 <u>66</u> , to <u>Apr. 7</u> 19 <u>66</u> , that I last saw the deceased alive on <u>Apr. 7</u> 19 <u>66</u> , and that death occurred at <u>6:30 M.</u> from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>324 Main St.</u> DATE SIGNED <u>4/12/66</u> | | | | | | | |
| ACTUAL SIGNATURE <u>C. G. Rawley</u> M.D. <u>Crisfield, Maryland</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>C. G. Rawley, M.D.</u> <u>Crisfield, Maryland</u> | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 14, 1966</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Nesley</u> | | 22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Md. Som. Co.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hart-Marion Sta., Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 14 1966</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Somerset MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover, Md. Rt. 1 #193 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | d. STREET ADDRESS — | |
| 3. NAME OF DECEASED (Type or print) First Estella Middle Maddox Last Maddox | | 4. DATE OF DEATH Month April Day 21 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 18, 1886 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR Months — Days — | 11. IF UNDER 24 HRS Hours — Min — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Westover, Som. Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Noah Collins | | 14. MOTHER'S MAIDEN NAME Nancy Ballard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No. | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Ida Collins-Westover, Md. Rt. 1 #193 | | Address Ida Collins-Westover, Md. Rt. 1 #193 | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Bronchitis 5021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exposure to Cold DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis & Pulis Degeneration | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour — o. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb 10, 1965 to April 21, 1966 , that I last saw the deceased alive on April 18, 1966 , and that death occurred at 6:25 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Estella J. Maddox M.D. | | DATE SIGNED April 25, 1966 | |
| PHYSICIAN'S NAME (Type) Estella J. Maddox | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) APR. 24-66 | 22b. DATE THEREOF APR. 24-66 | 22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery | 22d. LOCATION (City, town, or county) (State) Westover, Som. Co., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Stark-Maxion, Md. | | 24a. REC'D BY REGISTRAR Charles Judge | 24b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--------------------------------------|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 05941 CERTIFICATE OF DEATH 05941 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN ID Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mariners Section | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Mariners Section e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First SADIE Middle FONZY Last OUTTEN | | | | | 4. DATE OF DEATH Month April Day 12 Year 19 66 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 4, 1910 | | 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (County & State, or foreign country) Deal Island, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Milbourne Elliott, Sr. | | | | | 14. MOTHER'S MAIDEN NAME Fannie Crockett | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Maurice Outten, same as 2 a.b.c.d. above Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 , to 4/11 , 19 66 that (I) (we) last saw the deceased alive on 4/11 , 19 66 and that death occurred at 6 AM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Robert E. Roberts | | | | | 22b. DATE SIGNED 4/12/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert E. Roberts, M.D. | | | | | 22d. ADDRESS 512 W. Main St.-Crisfield, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 15, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Memorial Park | | | 23d. LOCATION (City, town or county) Crisfield, Md. (State) _____ | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons--Crisfield, Md. | | | | | 25a. REC'D BY REGISTRAR APR 20 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sackertown Rd. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Sackertown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CLARENCE Middle COCHRANE Last RIGGIN | | | 4. DATE OF DEATH Month April Day 23 Year 1966 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 23, 1891 | | 9. AGE (in years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer | | 10b. KIND OF BUSINESS OR INDUSTRY Retail Seafood | | 11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md. | | | |
| 13. FATHER'S NAME D. Qui nn Riggins | | | 14. MOTHER'S MAIDEN NAME Mariah Sterling | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-14-9676 | | 17. INFORMANT Mrs. Mildred W. Riggins, Same as 2, above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 5211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Side Heart Failure DUE TO (c) Emphysema: Severe | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hr. 3 yr. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from July 1963 to 4/22, 1966 , that (I) (we) last saw the deceased alive on 4/22 1966 and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Robert E. Roberts M.D. | | | | 22b. DATE SIGNED 4/23/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert E. Roberts, M.D. | | | | 22d. ADDRESS Crisfield, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 26, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery | | | |
| 23d. LOCATION (City, town or county) (State) Crisfield, Md. | | 24. FUNERAL DIRECTOR Bradshaw & Sons-- Crisfield, Md. | | | | | |
| 25a. REC'D BY REGISTRAR APR 28 1966 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a temporary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05946

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b 19-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (DOA) McCready Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 136 S. 4th Street. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIE J. SMITH | | 4. DATE OF DEATH Month Apr. Day 4 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 28, 1899 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. USUAL RESIDENCE (Give kind of work done during most of working life, even if retired) Laborer | 11. BIRTHPLACE (State or foreign country) Brundidge, Alabama |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Willie Smith | |
| 14. MOTHER'S MAIDEN NAME Fanny Smith | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Beatrice Lankford Address Same as 2 a.b.c.d. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE C. G. Rawley | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) C. G. Rawley, M. D. | | 22. DATE SIGNED 4/8/66 Crisfield, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/10/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery | | 23d. LOCATION (City, town or county) (State) Crisfield Md. | |
| 24. FUNERAL DIRECTOR Anthony E. Ward | | 25a. REC'D BY REGISTRAR APR 11 1966 DATE 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jacksonville Rd. | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS Jacksonville Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First OTIS Middle CLINTON Last WARD | | | | | | 4. DATE OF DEATH Month April Day 11 Year 1966 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 16, 1917 | | 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Dealer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | | 11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Murray E. Ward | | | | | | 14. MOTHER'S MAIDEN NAME Blanche O. Ward | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Lorraine Ward-Jacksonville Rd.-Crisfield, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis + Uremia 1-1X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach & Metastases OUE TO OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiectasis - 6 years | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb , 19 66 , to April 11 , 19 66 , that (I) (we) last saw the deceased alive on April 8 19 66 , and that death occurred at 6 P. M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE A. N. Barr | | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 4/12/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D. | | | | | | 22d. ADDRESS Crisfield, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 13, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery | | | | 23d. LOCATION (City, town or county) (State) Crisfield, Md. | | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons-- Crisfield, Md. | | | | | | 25a. REC'D BY REGISTRAR APR 18 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1 (M)
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 15. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PW-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--------------------------------|---|--|--|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Somerset MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne | | c. LENGTH OF STAY IN 1b Life time | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Joseph R Waters | | First Middle Last | | 4. DATE OF DEATH 4-14-66 | | Month Day Year 19 | |
| 5. SEX male | 6. COLOR OR RACE col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-15-91 | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Tailer | | 11. BIRTHPLACE (State or foreign country) Princess Anne, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alford Waters | | | | 14. MOTHER'S MAIDEN NAME Rosa Banks | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Address (Street, city, town, or county) Somerset 4-18-66 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-18-66 | | 22c. NAME OF CEMETERY OR CREMATORY John Wesley | | 22d. LOCATION (City, town, or county) (State) Princess Anne, Md. | |
| 23. FUNERAL DIRECTOR William H James Jr Princess Anne, Md | | | | 24a. REC'D BY REGISTRAR APR 20 1966 | | 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MEDICAL CERTIFICATION

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© 1997 Blackwell Science Ltd

1992

1000

using a 1000 Hz tone.

[illegible]

2

4. $\frac{1}{2} \times 100 = 50$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Edw. W. McCready Memorial Hosp. | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 112 Locust St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last Wilson | | | | | | 4. DATE OF DEATH Month April Day 8 Year 1966 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 7, 1901 | | 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | | | 10b. KIND OF BUSINESS OR INDUSTRY City of Crisfield | | 11. BIRTHPLACE (County & State, or foreign country) Somerset - Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Harry Wilson | | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Helen Wilson | | | | Address Crisfield, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/7/66 , 1966 4/8 , 1966 that (I) (we) last saw the deceased alive on April 8 , 1966 , and that death occurred at 5:20 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE R. E. Roberts | | | | | | 22b. DATE SIGNED APR 14 1966 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) R. E. Roberts, M.D. | | | | | | 22d. ADDRESS Crisfield, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF Apr. 11, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery | | 23d. LOCATION (City, town or county) (State) Crisfield, Md. | | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons - Crisfield, Md. | | | | | | 25a. REC'D BY REGISTRAR APR 14 1966 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

100-20

RECEIVED
JAN 10 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-20)
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible body text]

Very truly yours,
[Illegible Signature]
Special Agent in Charge
Enclosure
100-20
JAN 11 1961
FBI - NEW YORK